NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

September 19, 2014

Centers for Medicare & Medicaid Services
200 Independence Ave., SW
Washington, DC 20201

RE: Healthy Indiana Plan (HIP) 1115 Application

Dear Administrator Tavenner:

The National Women's Law Center strongly supports the Department of Health and Human Services' efforts to implement the Patient Protection Affordable Care Act (ACA) and make quality, affordable health insurance available to millions of American women.

Since 1972, the National Women's Law Center has worked to protect and advance the progress of women and their families in core aspects of their lives, with an emphasis on the needs of low-income women. With a staff of over sixty, supplemented by legal fellows, interns, and pro bono assistance throughout the year, the Center utilizes a wide range of tools—including public policy research, monitoring, and analysis; litigation, advocacy, and coalition-building; and public education—to achieve gains for women and their families in education, employment, family economic security, health, and other critical areas. The National Women's Law Center has long advocated for women's health care and reproductive rights. The Center's efforts reflect extensive research and expertise regarding women's specific health needs.

We fully support Indiana's decision to accept Federal Medicaid funding to expand coverage for the over 350,000 Hoosiers who would be newly eligible for Indiana's Healthy Indiana Plan (HIP). However, we have serious concerns about Indiana's 1115 waiver request. We urge CMS to address our concerns about Indiana's wavier proposal detailed in this letter.

We are pleased to submit the following comments in response to the Healthy Indiana Plan (HIP) 2.0 1115 Waiver released on August 22, 2014.

Section 4: HIP 2.0

We are concerned about the complexity of the Healthy Indiana Plan and the ability of enrollees to understand the details of the plan. The current structure of the waiver requires enrollees to manage their POWER account; understand the financial implications of health savings accounts, premiums, and cost-sharing; and some must choose between two coverage options. The waiver application states that POWER accounts will "incentivize all HIP members to be prudent utilizers of health care, managing their account appropriately and seeking preventive care."[1] However, this assumption does not take into account the unique challenges facing the low-income individuals this plan seeks to cover.

To be "prudent utilizers of heath care" and manage their health savings account, beneficiaries must have a high level of health literacy as well as an understanding of how health insurance

operates. Research shows, though, that health insurance literacy is lower among individuals with low levels of education and adults living in poverty. Additionally, compared with uninsured adults with family incomes above Medicaid income-eligibility, uninsured adults eligible for Medicaid are significantly less confident in their understanding of key health insurance concepts.[2]

The HIP proposal does not explain how beneficiaries will be educated on how to use their coverage or how to manage a health savings account, nor does it address the types of information Indiana will provide to beneficiaries or how Indiana will take into account the specific needs of this population in understanding the complexity of HIP. CMS should require assurances from the state that Indiana will address these issues as a condition of waiver approval. .

4.1 Eligibility

CMS should deny the state's request to waive retroactive eligibility. Indiana's request to waive retroactive eligibility for the newly eligible low-income adults does not provide any demonstrative value other than to put newly eligible beneficiaries at risk of medical debt and providers at risk for bad debt. None of the recently approved expansion demonstrations – Arkansas, Iowa, Michigan and Pennsylvania – include such a provision, and we urge you to deny this request.

4.3.5.2 Pregnant Women and Section 1931 Parents and Caretaker Relatives

We appreciate Indiana's proposal to allow pregnant women to choose between their HIP plan and pregnancy-related Medicaid coverage, as well as their assurances that all cost-sharing and premiums will be waived for pregnant women. However, we are concerned that pregnant women enrolled in employer sponsored plans through HIP Link may not receive full Medicaid benefits during pregnancy. Regardless of which aspect of HIP 2.0 an eligible pregnant woman is enrolled in, she should have access to the full array of Medicaid maternity services.

4.4.1 Required Contributions

Allowing Indiana to impose premiums in the form of POWER account contributions on people with incomes below the poverty line, including those with little or no income, would set a new and dangerous precedent in the Medicaid program. Indiana is proposing to require HIP Plus enrollees to make monthly contributions to their POWER accounts, which are similar to health savings accounts, to help beneficiaries meet HIP 2.0's deductible. These monthly contributions must be treated as premiums under section 1916(a)(1) of the Social Security Act.

If approved, Indiana's plan would be the first Medicaid demonstration project approved since the creation of a mandatory group of low-income individuals (under section 1902(a)(10)(A)(i)(VII) of the Social Security Act) to include premiums for adults with incomes below 50 percent of the poverty line. Charging premiums to people with very low incomes is not an appropriate use of demonstration authority because experience already shows that premiums decrease enrollment of very low-income beneficiaries.

Premiums have already been shown to limit enrollment of eligible people in HIP. Currently many HIP enrollees (23 percent as reported in the HIP 2012 evaluation) do not have to pay premiums as they have no income. The 2012 HIP evaluation also showed that 17 percent of

those found eligible for HIP were never enrolled because they could not pay their initial premium. The original HIP program covered people with incomes up to 200 percent of the poverty line, but well more than half (69 percent) of those who did not enroll because of non-payment had incomes below the poverty line. Finally, of those who did enroll, 12 percent lost coverage because they failed to pay premiums, and 58 percent of those losing coverage had incomes below the poverty line.

Individuals below poverty are not provided an appropriate "choice" for coverage. Given the longstanding and robust body of evidence showing the negative effects the use of premiums and cost sharing have on low-income beneficiaries, we do not believe that the proposed HIP Basic and HIP Plus programs offer a real "choice" to the newly eligible adults. As described above, premiums can lower, if not deter, program participation. Moreover, the use of cost sharing, such as copayments, deters individuals from seeking care, including necessary care. Indiana could require cost-sharing that is below the maximum allowed by CMS to make the "choice" of coverage options less coercive. Indiana could also provide the same benefit package for HIP Basic and HIP Plus.

Additionally, Indiana proposes to require premiums which will, in some cases, be more expensive than the cost of private plans on the Marketplace. Hoosiers with family incomes between 100 and 138 percent of poverty are currently eligible to buy plans on the Marketplace and could be paying less now than they would under HIP 2.0.

Indiana has proposed contributions for adults with incomes above poverty of $25 per month ($300 per year). These proposed contributions are higher than premiums for adults at the same income level on the Marketplace. The expected contribution for coverage on the Marketplace with an income at 101% of the FPL for one adult is $232 per year. In many cases, consumers may have a choice of coverage on the Marketplace that would cost them even less than the expected contribution used to calculate their premium credit. At this income level, Indiana's proposed premiums are $70 more per year for a single person. CMS must require that premiums for beneficiaries enrolled in HIP are not higher than what they would be paying on the Marketplace.[3]

4.4.2 Non-Payment Penalties

Indiana's waiver proposal would allow the state to make monthly contributions to the POWER account a condition of continuing eligibility for individuals with incomes over 100% of poverty. If enrollees are unable to pay their contributions, they could be locked out of coverage for six months.

Indiana's waiver states that HIP "encourages members to maintain insurance coverage throughout the year instead of waiting to seek coverage whey are ill;" however, research suggests that Indiana's proposed use of required contributions and lockout periods will not help the state achieve this goal. Evaluations of the Children's Health Insurance Program (CHIP) show that premium payments and lockout periods reduce retention in the program. Premiums reduce retention because children may disenroll if their family cannot afford to pay premiums or because of administrative obstacles that make it difficult to actually pay premiums. Lockout provisions, like the one proposed by Indiana, further reduced retention in CHIP and are associated with increases in disenrollment as well as reenrollment after the lockout period.

Additionally, lockout periods will inevitably disrupt continuity of care, which would be particularly harmful for women, who are more likely to manage chronic conditions. If lockout periods are imposed on beneficiaries, women would also experience major disruptions in access to critical services such as contraception and other timely family planning services.

Indiana's proposal also requires individuals to make a premium payment before coverage can begin. Individuals have up to 60 days to make their premium payment. Individuals will remain uninsured during this 60-day period. This delay is a barrier to coverage, which does not further the objectives of the Medicaid program.

CMS should deny Indiana's proposals to create a lockout period for nonpayment of required contributions and delay coverage for new enrollees.

4.4.4 POWER Account Rollover

The waiver outlines a system by which HIP will rollover an individual's POWER account balance to offset the required contribution in the next benefit year if an individual receives at least one age- and gender-appropriate preventive service. We strongly support coverage of preventive services and work hard to make sure women can access these services, but this approach raises privacy concerns.

Conditioning the rollover of an individual's POWER account on use of preventive care services may exacerbate privacy and confidentiality concerns that already exist with respect to certain preventive care services. Family planning services and testing for sexually transmitted infections, for example, can raise particularly sensitive privacy concerns which can lead people to delay or forgo seeking such care. While the POWER account rollover proposal is meant to incentivize individuals' use of preventive services, failure to adequately protect patient privacy and ensure confidentiality may have a deterrent effect.

Each of the actors involved in handling information through HIP are covered entities under the Health Insurance Portability and Accountability Act (HIPAA) and thus have obligations to protect patient privacy. The State must make assurances that each of these entities comply with HIPAA as they handle this sensitive patient information, in particular with respect to the POWER account rollover system.

We are also concerned that women will be disadvantaged by the POWER account rollover proposal. Women are more likely to manage multiple chronic conditions; have higher medical services utilization than men; are more likely to have ever visited a medical provider; and visit medical providers more frequently.[4] For women, aged 45-64, currently enrolled in public health insurance, the prevalence of 4 more chronic conditions was higher than among women with private coverage or without coverage.[5] Thus, women are less likely to have money leftover in their POWER account to rollover and will have to pay to the full premium each year. We urge CMS to require Indiana to address this inequity.

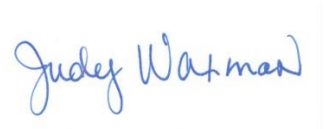
8.1 Title XIX Waivers

The Indiana proposal would allow the state to limit Medicaid enrollees' freedom to seek care from the provider of their choice for all services, including family planning services and supplies. This limitation would also mean that the state would not need to pay for services

provided out-of-network. Both the Medicaid statute and CMS policymakers have recognized states' heightened obligations with regard to access to family planning services. Section 1902(a)(23)(B) of the Social Security Act guarantees that Medicaid beneficiaries can receive family planning services from any qualified Medicaid provider, even if the provider is outside of their Medicaid managed care network, while in Iowa's recent 1115 waiver approval, CMS required the state to "ensure payment of state plan rates of family planning services that the QHP considers to be out-of-network." We urge CMS to require Indiana to meet the same standard for HIP enrollees and other Indiana Medicaid beneficiaries.

Thank you for the opportunity to submit comments on about Indiana's 1115 waiver for the Healthy Indiana Plan (HIP) 2.0. We support Indiana's efforts to expand coverage for low-income Hoosiers but have serious concerns about this approach, which we urge CMS to address prior to waiver approval.

Sincerely,



Judith Waxman
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[1] Healthy Indiana Plan 2.0 1115 Waiver Application, 2014.
[2] Genevieve M. Kenney, et al. The Urban Institute. "Uninsured Adults Eligible for Medicaid and Health Insurance Literacy," available at http://hrms.urban.org/briefs/medicaid_experience.html.

[3] Based on Kaiser Family Foundation subsidy calculator for a household with 1 adult age 30, in Indiana, zip code 46201 (Indianapolis).
[4] O'Hara, Brett and Kyle Caswell, P70-133, "Health Status, Health Insurance, and Medical Services Utilization: 2010," Current Population Reports, U.S. Census Bureau, Washington, DC, 2012: https://www.census.gov/prod/2012pubs/p70-133.pdf
[5] Ward BW, Schiller JS. "Prevalence of Multiple Chronic Conditions Among US Adults: Estimates From the National Health Interview Survey, 2010." *Prev Chronic Dis* 2013;10:120203. Available at: http://www.cdc.gov/pcd/issues/2013/12_0203.htm.